



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

JUN 17 2009

Region IX
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Report Number: A-09-09-00079

Mr. Toby Douglas
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, MS 0002
Sacramento, California 95814

Dear Mr. Douglas:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicaid Credit Balances at French Hospital Medical Center as of February 28, 2009." We will forward a copy of this report to the HHS action official noted below.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-09-09-00079 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
MEDICAID CREDIT BALANCES
AT FRENCH HOSPITAL
MEDICAL CENTER
AS OF FEBRUARY 28, 2009**



Daniel R. Levinson
Inspector General

June 2009
A-09-09-00079

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In California, the Department of Health Care Services (the State agency) administers Medicaid.

Credit balances may occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the program payment ceiling or allowable costs, resulting in an overpayment. Credit balances may also occur when a provider receives payments for the same services from the Medicaid program and another third-party payer. In such cases, the provider should return the overpayment to the Medicaid program, which is the payer of last resort.

Section 1903(d)(2)(C) of the Act, implemented at 42 CFR § 433.300(b), states: “. . . when an overpayment is discovered . . . the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. . . . [T]he adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.”

The State agency does not have any regulations requiring providers to refund Medicaid credit balances within a specific timeframe. However, State Medicaid cost report instructions state that it is the provider’s responsibility to maintain an effective system to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments. In addition, providers must report outstanding credit balances as part of their annual cost report submissions and refund any overpayments when the State agency settles the cost reports.

French Hospital Medical Center (French), part of the Catholic Healthcare West system, is an acute care hospital located in San Luis Obispo, California. French reported that it was reimbursed by the State agency approximately \$1.4 million for Medicaid services during calendar year 2008.

OBJECTIVE

Our objective was to determine whether the Medicaid credit balances recorded in French’s accounting records as of February 28, 2009, for inpatient and outpatient services represented overpayments that French should have returned to the Medicaid program.

SUMMARY OF RESULTS

As of February 28, 2009, French's Medicaid credit balances did not include overpayments that should have been returned to the Medicaid program. Therefore, we are not making any recommendations to the State agency.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicaid Program	1
Federal and State Requirements	1
French Hospital Medical Center.....	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope	2
Methodology.....	2
RESULTS OF REVIEW	3

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In California, the Department of Health Care Services (the State agency) administers Medicaid.

Credit balances may occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the program payment ceiling or allowable costs, resulting in an overpayment. Credit balances may also occur when a provider receives payments for the same services from the Medicaid program and another third-party payer. In such cases, the provider should return the overpayment to the Medicaid program, which is the payer of last resort.

Federal and State Requirements

Section 1903(d)(2)(C) of the Act, implemented at 42 CFR § 433.300(b), states: “. . . when an overpayment is discovered . . . the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. . . . [T]he adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.”

The State agency does not have any regulations requiring providers to refund Medicaid credit balances within a specific timeframe. However, State Medicaid cost report instructions state that it is the provider’s responsibility to maintain an effective system to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments. In addition, providers must report outstanding credit balances as part of their annual cost report submissions and refund any overpayments when the State agency settles the cost reports.

Providers must submit their annual Medicaid cost reports within 150 days after the end of the provider fiscal year. Pursuant to section 14170(a)(1) of the California Welfare and Institutions Code, the State agency has 3 years after the provider’s fiscal year or the date of the submission, whichever is later, to audit or review the cost report.

French Hospital Medical Center

French Hospital Medical Center (French), part of the Catholic Healthcare West system, is an acute care hospital located in San Luis Obispo, California. French reported that it was

reimbursed by the State agency approximately \$1.4 million for Medicaid services during calendar year 2008.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Medicaid credit balances recorded in French's accounting records as of February 28, 2009, for inpatient and outpatient services represented overpayments that French should have returned to the Medicaid program.

Scope

French's inpatient and outpatient accounting records contained six Medicaid accounts with credit balances as of February 28, 2009. We reviewed four outpatient accounts and two inpatient accounts.

Our objective did not require an understanding or assessment of the complete internal control system at French. We limited our review of internal controls to obtaining an understanding of the policies and procedures that French used to review credit balances and report overpayments to the State Medicaid program.

We performed our fieldwork at French's business office in Santa Maria, California, from April through June 2009.

Methodology

To accomplish our objective, we:

- reviewed Federal and State requirements pertaining to Medicaid credit balances and overpayments;
- reviewed French's policies and procedures for reviewing credit balances and reporting overpayments to the State agency;
- reconciled French's February 28, 2009, total credit balances report to the trial balance;
- identified French's Medicaid credit balances from its accounting records and reconciled the Medicaid credit balances to French's Medicaid credit balances report as of February 28, 2009;

- reviewed French's Medicaid claim forms and remittance advices, patient accounts receivable detail, and additional supporting documentation for each credit balance account; and
- coordinated our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusion based on our audit objective.

RESULTS OF REVIEW

As of February 28, 2009, French's Medicaid credit balances did not include overpayments that should have been returned to the Medicaid program. Therefore, we are not making any recommendations to the State agency.